STATEMENT OF CONSIDERATION RELATING TO
907 KAR 1:563

Department for Medicaid Services
Amended After Comments

(1) A public hearing regarding 907 KAR 1:563 was not requested and; therefore, not held.

(2) The following individuals submitted written comments regarding 907 KAR 1:563:

Name and Title	Organization/Agency/Other Entity
William S. Dolan, Staff Attorney Supervisor	Protection & Advocacy; Frankfort, KY

(3) The following individual from the promulgating agency responded to comments received regarding 907 KAR 1:563:

Name and Title	Organization/Agency/Other Entity
Catherine York, Attorney	Cabinet for Health and Family Service, Office of Legal Services
Stuart Owen, Regulation Coordinator	Department for Medicaid Services

(1) Subject: Continuation of Medicaid Covered Services

(a) Comment: William S. Dolan, Staff Attorney Supervisor of Protection & Advocacy, stated the following:

“Section 5 as amended violates federal constitutional and regulatory law as it limits the types of services that cannot be reduced or terminated if the individual files a timely appeal. If a service is not listed in Section 5, then there is no mechanism in the regulation as amended to continue that service during the pendency of the Medicaid appeal. Services like transportation, Early and Periodic Screening, Diagnosis, and Treatment for children, oxygen supplies, and scores of other services are not listed and thus terminated pending appeal. This is about balancing two worthy, yet inherently abrasive goals—responsible stewardship of the fisc and providing medically necessary services. Federal law tells us to put the emollient on the services and provide aid pending appeal.

Kentucky’s Medicaid Fair Hearing system must comply with federal fair hearing requirements. 42 C.F.R. § 431.205(d). (“The hearing system must meet the due process

standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional standards specified in this subpart.”). *See also Moffitt v. Austin*, 600 F. Supp. 295, 298 (W.D. Ky. 1984) (‘The hearing system must meet the due process standards enunciated in *Goldberg* as well as any additional standards set forth in the Social Security Act or the regulations promulgated pursuant to that Act.’).

42 C.F.R. § 431.230 is a federal fair hearing requirement that obliges Kentucky to maintain Medicaid services if the recipient files a timely appeal. ‘The agency may not terminate or reduce services until a decision is rendered after the hearing . . . .’ *Id*. The one accepted exception to this rule is recognized in Section 5, Sub-section (3) of 907 KAR 1:563 which provides that ‘[s]ubsection (1) of this section shall not apply if the Medicaid Program service has been reduced or discontinued as a result of a change in law or administrative regulation.’ There are no other exceptions and nothing in 42 C.F.R. § 431.230 allows Kentucky to limit aid pending appeal to just a handful of services.

The *Moffitt* Court held that ‘federal regulations provide that any patient who is dissatisfied with an action taken by the agency may request a hearing. 42 C.F.R. § 431.220. If a recipient requests a hearing, his services **cannot** be reduced or terminated by the agency until after the hearing. 42 C.F.R. § 431.230.’ (emphasis supplied). *Moffitt*, 600 F. Supp. at 298. The U.S. Supreme Court recognized in *Goldberg* that ‘termination of aid pending resolution of a controversy over eligibility may deprive an eligible recipient of the very means by which to live while he waits.’ *Goldberg*, 397 U.S. at 264. Medicaid recipients have a property interest in the continued receipt of services. *Moffitt*, 600 F. Supp. at 297. Accordingly, Medicaid benefits cannot be terminated before a hearing. *Id*. at 299.

The District Court for the Eastern District of Texas examined 42 C.F.R. § 431.230 in *Jonathan C. v. Hawkins*, No CIV.A.9:05-CV-43, 2006 WL 3498494 (E.D. Tex. Dec. 5, 2006). Texas Medicaid terminated Jonathan’s Medicaid-funded nursing services prior to his fair hearing. The District Court held that this violated his rights because, inter alia, Texas did not maintain aid pending the appeal. *Id.* at *14.

> The Court finds Jonathan's situation to be problematic and violative of the spirit of the Medicaid Act when a beneficiary such as him has been receiving the same amount of medially (sic) necessary, physician-directed benefits for years and then is suddenly denied those benefits without recourse before they are reduced or terminated without notice or hearing. This contravenes the clear directive of the Medicaid Act and basic due process rights delineated in *Goldberg v. Kelly*, specifically the requirements that beneficiaries receive the benefits to which they are entitled, that the beneficiary is entitled to due process when the state denies or reduces the requested benefits, and that those benefits be maintained until a fair hearing is held and a decision reached. *Id*. at *13.

The California Court of Appeals reached the same conclusion in *Frank v. Kizer*, 213 Cal. Ct. App. 3d 919, 925 (1989) and observed that the federal regulators were aware of the competing concerns between the state's fiscal bottom line and the recipients' need for medically necessary services and choose to favor the recipients.

We suggest that the Cabinet adhere to Due Process, *Goldberg v. Kelly*, and federal regulatory law and permit Medicaid recipients to maintain any Medicaid service until the Cabinet issues its final hearing decision order. "It is clear to the court that the Fifth Amendment, *Goldberg v. Kelly*, and the federal regulations require a hearing before benefits are suspended." (Italics supplied). *Moffitt*, 600 F. Supp. at 299. Ms. Frank, the plaintiff in *Kizer*, 'had to borrow money and cut back on food in order to pay her oxygen costs' because Medicaid refused to pay for services during the pendency of her appeal. *Frank,* 213 Cal. App. at 922. The Cabinet should not create, through regulatory policy, a Kentucky 'Ms. Frank.'"

(b) Response: The Department for Medicaid Services (DMS) is deleting the language which excludes the right to continue to receive services to solely nursing facility services, services in an intermediate facility for individuals with an intellectual disability, and home and community based waiver services from the administrative regulation (via an amended after comments regulation) and inserting language from 42 C.F.R. 431.230. Additionally, DMS is inserting language which clarifies that a request by a recipient to receive an amount or care or number of services subsequent to receiving, in full, a previously authorized amount of care or number of services, the new request shall not be considered a continuation of the prior amount of care or number of services. For example, if a recipient is approved to have fifteen (15) physical therapy visits and receives the therapy in full, a new request to receive ten (10) physical therapy treatments is not a continuation of the previous fifteen (15) visits.

The revised language reads as follows (amendments are bold-faced):

"Section 5. Continuation of Medicaid Covered Services. (1)**(a) Except as established in paragraphs (b) or (c) of this subsection or subsections (2), (3), or (4) of this section,** if a[~~the~~] request for a [~~cabinet level administrative~~] hearing is postmarked or received within ten (10) days of the advance notice date of denial **[~~for any of the following types of denials~~]**, the individual shall remain eligible for the care, program participation, or service denied until the date that the final hearing decision order is rendered in accordance with Section 9 of this administrative regulation.

(b) The individual shall not remain eligible for the care, program participation, or service denied if:

1.a. It is determined at the hearing that the sole issue is one of federal or state law or policy; and

b. The department promptly informs the individual in writing that the services shall be terminated or reduced pending the hearing decision;

2. The individual's eligibility for time-limited benefits has expired; or

3. The individual has already received in full the specified amount of care or

number of services that were authorized by the department.
(c) A request for an amount of care or number of services subsequent to receiving a previously authorized amount of care or number of services in full shall not be considered a continuation of the previously authorized amount of care or number of services.[~~:~~
~~(a) Denial that an individual meets patient status criteria to qualify for nursing facility services pursuant to 907 KAR 1:022;~~
~~(b) Denial that an individual meets patient status criteria to qualify for ICF IID services pursuant to 907 KAR 1:022;~~
~~(c) Denial that an individual meets nursing facility level of care criteria, nursing facility patient status criteria, or ICF IID patient status criteria pursuant to 907 KAR 1:022 to qualify for home and community based waiver services; or~~
~~(d) Denial of a home and community based waiver service~~][~~specified on the notice for denial of level of care, a Medicaid vendor payment for nursing facility, intermediate care facility for the mentally retarded and developmentally disabled, or home- and community-based waivers services shall continue until the date the final cabinet level hearing decision order is rendered in accordance with Section 9 of this administrative regulation.~~**]**
(2)**[~~Subsection (1) of this section shall not apply to a Medicaid Program service not stated in subsection (1) of this section.~~**
~~(3)~~] Subsection (1) of this section shall not apply if the Medicaid Program service has been reduced or discontinued as a result of a change in law or administrative regulation.
(3)[~~(4)~~] Time-limited benefits shall not be extended based on a request for a hearing.
(4)[~~(5)~~] If a request for a[~~the request for a cabinet level administrative~~] hearing is postmarked or received from a recipient within ten (10) days of the advance notice of an adverse PASRR determination made in the context of a resident review, the department shall continue to reimburse[~~a Medicaid vendor payment~~] for nursing facility services [~~shall continue~~] until the date that the final **order**[~~the cabinet level administrative~~] **[~~hearing decision~~]** is rendered."

(2) Subject: Continuation of Medicaid Covered Services

(a) Comment: William S. Dolan, Staff Attorney Supervisor of Protection & Advocacy, stated the following:

"Section 13 limits the fees an attorney can charge a recipient or applicant for hearing representation. Please clarify that the fee limitation only applies to recipients or applicants and that a 3rd party can negotiate to pay any fee amount with an attorney on behalf of recipients or applicants. We suggest adding the following:

(3) The fee limitations in Section 13 only apply to the amount an attorney can charge a recipient or applicant. The amount an attorney can collect from any other person or entity who is not a recipient or applicant for representation in all categories of Medicaid is a matter between the attorney and other person or entity."

(b) Response: DMS is inserting new language as follows in an "amended after

comments" administrative regulation:

"(3)(a) The fee limitations stated in subsection (1) shall:
1. Apply to the amount an attorney may charge a recipient or applicant; and
2. Not apply to the amount an attorney may collect from another entity or person who represents the recipient or applicant in all categories of Medicaid.
(b) The amount an attorney may collect from an entity or person who is not a recipient or applicant for representing the recipient or applicant in all categories of Medicaid shall:
1. Be a matter between the attorney and other entity or person; and
2. Not be a matter that involves the department or cabinet."

(3) Subject: Definition of Authorized Representative

(a) and (b) Comment and Response: The Department for Medicaid Services (DMS) is making an amendment to the definition of authorized representative in order to accommodate legal guardians as individuals who have a legal guardian are not authorized, in certain cases, to provide written consent.

DMS is amending the definition of "authorized representative" in an "amended after comments" administrative regulation to read as follows (amendments are bold-faced):

(4)[~~(2)~~] "Authorized representative" means**:**
(a) For a recipient or applicant who is authorized by Kentucky law to provide written consent, an individual or entity [~~or guardian~~] acting on behalf of, and with written consent from, **the[~~a~~]** recipient or **the** applicant**; or**
(b) A legal guardian.

(4) Subject: De Novo Hearing/Review of Record of Hearing

(a) and (b) Comment and Response: The Department for Medicaid Services (DMS) is inserting language in an amended after comments administrative regulation addressing an applicant/recipient's right to request a de novo hearing or review of the record of a hearing as established in 42 CFR 431.233. Previously, the administrative regulation failed to refer to this option to which applicants/recipients are entitled.

(5) Subject: Use of Terms Recommended Order and Final Order

(a) and (b) Comment and Response: The Department for Medicaid Services (DMS) is replacing language in the administrative regulation regarding hearing decisions by using the terms "recommended order" and "final order" as those are the terms used in the applicable statute – KRS 13B.010.

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 1:563 and is amending the administrative regulation as follows:

Page 2
Section 1(4)
Line 9
After “means”, insert a colon and the following:
(a) For a recipient or applicant who is authorized by Kentucky law to provide written consent,

Line 10
After “from,”, insert “the”.
Delete “a”.

After “or”, insert “the”.

After “applicant”, insert the following:
; or
(b) A legal guardian

Page 2
Section 1(8)
Line 16
After “(8)”, insert the following:
“Final order” is defined by KRS 13B.010(6).
(9)

Page 2
Sections 1(9), (10), and (11)
Lines 17, 19, and 22
Renumber these three (3) subsections by inserting “(10)”, “(11)”, and “(12)”, respectively, and by deleting “(9)”, “(10)”, and “(11)”, respectively.

Page 3
Sections 1(12), (13), (14), (15), and (16)
Lines 1, 2, 4, 5, and 7
Renumber these five (5) subsections by inserting “(13)”, “(14)”, “(15)”, “(16)”, and “(17)”, respectively, and by deleting “(12)”, “(13)”, “(14)”, “(15)”, and “(16)”, respectively.

Page 3
Section 1(16)
Line 7
After “KRS 205.8451(9).”, insert a return and the following:
(18) “Recommended order” is defined by KRS 13B.010(5).
(19)

Page 3
Sections 1(17) and (18)
Lines 8 through 14
Delete subsection (17) in its entirety and delete “(18)”.

Page 5
Section 5(1)
Line 16
After “(1)”, insert the following:
(a) Except as established in paragraphs (b) or (c) of this subsection or subsections (2), (3), or (4) of this section,

Line 18
After “denial”, delete the following:
for any of the following types of denials

Line 21
After “regulation.”, insert the following:
(b) The individual shall not remain eligible for the care, program participation, or service denied if:
1.a. It is determined at the hearing that the sole issue is one of federal or state law or policy; and
b. The department promptly informs the individual in writing that the services shall be terminated or reduced pending the hearing decision;
2. The individual’s eligibility for time-limited benefits has expired; or
3. The individual has already received in full the specified amount of care or number of services that were authorized by the department.
(c) A request for an amount of care or number of services subsequent to receiving a previously authorized amount of care or number of services in full shall not be considered a continuation of the previously authorized amount of care or number of services.

Delete the colon

Page 5
Section 5(1)(a), (b), (c), and (d)
Line 22 through
Page 6

Line 6
Delete paragraphs (a) through (d) in their entirety

Page 6
Section 5(2) and (3)
Lines 12 - 14
After “(2)”, delete the following:
Subsection (1) of this section shall not apply to a Medicaid Program service not stated in subsection (1) of this section.
(3)

Page 6
Section 5(4) and (5)
Lines 16 and 17
Renumber these two (2) subsections by inserting “(3)” and “(4)”, respectively, and by deleting “(4)” and “(5)”, respectively.

Page 6
Section 5(5)
Line 21
After “final”, insert “order”.

After “~~administrative~~]”, delete “hearing decision”.

Page 7
Section 6(2)(c)
Line 18
Insert a space between “the” and “hearing”.

Page 9
Section 9, Title
Line 13
After “Section 9.”, insert “Recommended Order”.
Delete “The Cabinet Level Decision”.

Page 9
Section 9(1)
Line 14
After “recommended”, insert “order”.
Delete “decision”.

Page 9
Sections 9(2), (3), and (4)
Lines 15 through 19
After “(2)”, delete the remainder of subsection (2), delete subsection (3) in its entirety, and delete “(4)”.

Page 9
Section 9(4)
Line 19
After “recommended”, insert “order”.
Delete “decision”.

Page 9
Section 9(5)
Line 22
After “recommended”, insert “order”.
Delete “decision”.

Page 10
Section 9(5)(a)
Line 2
After “recommended”, insert “order”.
Delete “decision”.

Page 10
Section 10, Title
Line 5
After “of”, insert “Recommended Order”.

After “~~Level~~]”, delete “Hearing Decision”.

Page 10
Section 10(2)
Line 8
After “(2)”, insert the following:

If a party wishes to file an exception to the recommended order, the exception shall be filed with the cabinet within fifteen (15) days from the date that the recommended order is mailed.

(3) A final order shall be issued within ninety (90) days from the date of the request for a hearing.

(4)(a) In accordance with 42 C.F.R. 431.233, an applicant or recipient shall have a right to request a:

1. Cabinet level review of the record of the hearing; or

2. De novo hearing at which the party may offer:

a. Evidence not presented at the hearing below; and

b. The evidentiary record of the fair hearing.

(b) If the applicant or recipient does not specifically request a de novo hearing, the cabinet level review shall determine whether the:

1. Recommended order was supported by substantial evidence in the record; and

2. Law was applied correctly.

Page 10
Section 10(2)
Line 9
After “of the”, insert “final order”.
Delete “decision”.

Page 10
Section 10(3)
Line 10
Renumber this subsection by inserting “(6)” and by deleting “(3)”.

Page 11
Section 12(1)
Line 5
After “department’s”, delete “state fair”.

Page 12
Section 13(2)
Line 18
After “recipient.”, insert a return and the following:

(3)(a) The fee limitations stated in subsection (1) shall:
1. Apply to the amount an attorney may charge a recipient or applicant; and
2. Not apply to the amount an attorney may collect from another entity or person who represents the recipient or applicant in all categories of Medicaid.
(b) The amount an attorney may collect from an entity or person who is not a recipient or applicant for representing the recipient or applicant in all categories of Medicaid shall:
1. Be a matter between the attorney and other entity or person; and
2. Not be a matter that involves the department or cabinet.